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UTILIZATION REVIEW AND CONTROL

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CHAPTER VI
UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and administration of the Fee for Service (FFS) behavioral health benefit programs under contract with DMAS. Magellan of Virginia is authorized to constitute, oversee, enroll, and train a provider network; render service authorizations; adjudicate and process claims; gather and maintain utilization data; reimburse providers; perform quality assessment and improvement activities; conduct member outreach and education; resolve member and provider issues; and perform utilization management of services and provide care coordination for members receiving FFS Medicaid-covered behavioral health services. Magellan of Virginia’s authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the BHSA or the MCOs if they are found to have billed these entities contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Department of Medical Assistance Services
Program Integrity Division
Supervisor, Provider Review Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Main Street
Richmond, Virginia 23219

Reports may be made to Magellan of Virginia via one of the following methods:

- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (DSS) or to the DMAS Member Audit Unit at (804) 786-0156. Reports are also accepted at the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: memberfraud@dmas.virginia.gov or forwarded to:

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Recipient Audit Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS. More information about the PUMS process is located in Chapter IV of this provider manual.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid FFS enrolled individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Member Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services. Referrals may be made by telephone, FAX, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Program Manager, Recipient Monitoring Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his/her name and telephone number in case DMAS has questions regarding the referral.

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

Utilization Review - General Requirements

Utilization reviews of enrolled providers of ARTS covered services are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services,

then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.

- Health care entities with provisional licenses shall not be reimbursed by Medicaid.
- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the ASAM level of care, and medical or clinical necessity of the delivered service.
- Completion of the multidimensional assessment by a Credentialed Addiction Treatment Professional (CATP), Certified Substance Abuse Counselor (CSAC)/CSAC-Supervisee. The CATP must sign off if completed by CSAC and CSAC-supervisee.
- A copy of the provider's license/certification, staff licenses, and qualifications for the ARTS provider to ensure that the services were provided by appropriately qualified individuals and licensed facilities as defined in Chapter II of this manual.
- Verification that the delivered services as documented are consistent with the individual service plan (ISP), invoices submitted, and specified service limitations.
- A determination that the delivered services are provided by qualified staff and provider staffing plans meet DBHDS licensing requirements set forth in 12VAC35-105 as well as DMAS requirements set forth in 12VAC30-130-5000 et. all, 12VAC30-60-181 and 12VAC30-60-185.
- Service authorizations shall be required for American Society of Addiction Medicine (ASAM) Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0. The medical record content must corroborate information provided to the MCOs and the BHSA for acquiring the service authorization.
- A determination that the documentation in the member's medical record meets the requirements as set forth in the ARTS Documentation Requirements section of this chapter of the manual.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.

- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.
- Evidence that the service provider informed the primary care provider or pediatrician of the receipt of substance use disorder treatment services with appropriate releases meeting requirements of 42 CFR Part 2.
- Evidence that for members receiving substance use case management, the ARTS service provider collaborated with the substance use case manager and provided notification of the provision of services with appropriate consent meeting requirements of 42 CFR Part 2. In addition, the provider must send written monthly updates to the substance use case manager. The individual's Primary Care Provider (PCP) must be notified of services to ensure coordination of care. A written discharge summary must be sent to the PCP and substance use case manager within 30 days of the service discontinuation date. Only one type of case management can be provided at a time.

Services must meet the requirements set forth in 12VAC30-130-5000 et al and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, BHSA or its designated contractor(s) may be available to meet with provider staff for an Exit Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. Their request notice is considered filed when it is date stamped by the MCO for managed care enrolled members and to the BHSA or DMAS, or its designated contractor(s) for fee-for-service members. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, the MCO, DMAS, or its designated contractor(s) will contact the provider to conduct an

Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider

If a billing adjustment is needed, it will be specified in the final audit findings report. If a Plan of Correction is also offered and requested, the provider will have 30 days (unless otherwise indicated) from receipt of the final audit findings report to submit the plan to the MCO for managed care enrollees, or DMAS, or its designated contractor(s) for FFS enrollees for approval.

If the provider disagrees with the final audit findings report, they may appeal the findings by filing a reconsideration request with the MCO for managed care enrolled members to initiate the MCO reconsideration process. Before appealing to DMAS for audits performed by the MCO, providers must first exhaust all MCO reconsideration processes.

All provider appeals submitted to DMAS must be filed in writing with the DMAS Appeals Division and within 30 days of the MCO's final reconsideration decision, or, if the audit was conducted by DMAS (or a DMAS contractor), then within 30 days of the final overpayment letter issued by DMAS or its authorized contractor. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be considered untimely.

MEDICAL RECORDS AND RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of Medicaid covered services must be retained for not less than five years after the date of service or discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment,

conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 482.24 for additional requirements.

The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

CERTIFICATION AND RECERTIFICATION FOR HOSPITALIZATION

(ASAM Level 4.0 and ASAM Level 3.7 and 3.5 when provided by a hospital)

The Medical Assistance Program recognizes the physician as the key figure in determining utilization of health services; the physician determines the appropriateness of admission to a hospital; orders tests, drugs, and treatments; leads multidisciplinary treatment teams and determines the length of stay. In recognition of this responsibility, Medicaid calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Medicaid requires that payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished and, in certain instances, only if there is a physician's recertification as to the continued need for the covered services.

The provider of services is responsible for obtaining timely physician certification and recertification statements and for retaining them on file for verification, when needed by the intermediary or by this state agency. Providers are allowed some flexibility to determine the manner in which certification and recertification statements are obtained as long as the required information is included in the patient record and can be verified.

Admission Certification and Initial Individual Service Plan (ISP)

Federal regulations (42 CFR §456.60 and § 456.80) mandate that there must be an admission certification and ISP or plan of care to justify every Medicaid inpatient hospital admission. Compliance is monitored on a regular basis by Medicaid's utilization review staff. Noncompliance will result in reimbursement of the paid claim being recouped by Medicaid.

The certification (stating that inpatient services are needed by the patient) must be in writing and signed by an individual clearly identified as a licensed physician. The certification must be completed, signed, and dated within 24 hours of admission. Each certification and recertification statement is to be separately signed by a physician.

Certification and recertification statements may be provided on a separate form, or may be included in physician admission orders, progress notes, or other records a physician normally signs in caring for a patient, if the physician includes a statement indicating where the required information is contained in the patient's medical records. Alternatively, certification may be made with a stamp stating "Certified for Necessary Hospital Admission" which must be made an identifiable part of the patient records.

A written ISP must be completed within 24 hours of admission for each Medicaid recipient. If the individual applies for Medicaid while in the hospital, the ISP must be completed before payment for care can be authorized.

The initial ISP must be an identifiable part of patient records and must include:

- Member and family strengths and personal traits that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;
- Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the member;
- Measureable treatment objectives with short-term and long-term goals;
- Any orders for medications, psychiatric, medical, dental, and any special healthcare needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member and the staff person responsible for providing those services;
- Plans for continuing care, including review and modification to the ISP;
- Detailed discharge plan developed with the member; and
- Signature and date by the member or legally authorized representative, an addiction-credentialed physician or physician with experience in addiction medicine, or a physician extender and CATPs participating in the treatment team.
- The provider shall request releases of information from the member or legally authorized representative to release confidential information to collect information from medical and behavioral health treatment providers, schools, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the ISP.

The Comprehensive ISP must be an identifiable part of patient records and must include:

- Description of the multidimensional assessment including ASAM Dimensions 1-6 and a diagnostic clinical evaluation that includes examination of the medical, psychological,

social, behavioral, and developmental aspects of the member's situation and must reflect the need for the ASAM Level of Care;

- Documentation of the use of valid and reliable evidenced based assessment tools to gather clinical information;
- Description of any prior treatment information and testing that the member has received;
- Treatment objectives that includes the member's goals that shall include measurable, evidence-based, short-term and long-term goals and objectives, family engagement activities (as appropriate), and the design of community-based aftercare with target dates for achievement;
- Description of an integrated program of therapies, interventions, activities, and experiences designed to meet the treatment objectives related to the member's treatment needs; and
- Description of comprehensive transition plans and coordination of current care and post-discharge plans with related community services to ensure continuity of care upon discharge with the recipient's family, school, and community.

An admission certification and ISP may be similar to the sample forms for admission certification and plan of care in the "Exhibits" section in the DMAS Hospital Provider Manual is preferred in order to meet federal requirements in a uniform manner and shall include the ASAM Level 4.0 requirements for Medically Managed Intensive Inpatient services.

Recertification

Each recertification must be contemporaneously completed, signed, and dated by an individual clearly identified as a physician, physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician. The individual must recertify for each patient that inpatient services in a hospital are needed. Recertification must be completed, signed, and dated at least every 30 days after certification.

Certification and Recertification for Recipient Receiving Retroactive Eligibility

If any individual receives services before his or her entitlement to Medical Assistance Program benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. Example: If any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission. All required certifications and recertification's must be obtained before the provider requests payment for any portion of the inpatient stay.

CERTIFICATION AND RECERTIFICATION FOR RESIDENTIAL TREATMENT

(ASAM Level 3.3, 3.5 and 3.7 when provided by a residential treatment services provider)

The certification of need must be made by the team responsible for the plan of care within 14 days after admission and the certification shall cover any period of time after admission and before for which claims are made for reimbursement by Medicaid.

DOCUMENTATION REQUIREMENTS FOR ARTS

The provider's contract with DMAS, MCO or the BHSA requires that records fully disclose the extent of services provided to Medicaid members. Records must clearly document the medical or clinical necessity and document how the individual's service needs match the level of care criteria for the service. This documentation must be written at the time the service is rendered, must be legible, and must clearly describe the services rendered.

Some ARTS covered services require an approved service authorization prior to service delivery in order for reimbursement to occur. To obtain service authorization, all providers' information supplied to the MCO or the BHSA shall be fully substantiated throughout individuals' medical records. Providers must use the *Addiction and Recovery Treatment Services (ARTS) Service Authorization Review Form* for initial service authorization requests as the MCOs and the BHSA have agreed to utilize this one form for ARTS initial service authorization requests. Providers must use the *Addiction and Recovery Treatment Services (ARTS) Service Authorization Extension Review Form* for extension requests for the same ASAM level as the MCOs and the BHSA have agreed to utilize this one form for ARTS service authorization extension requests.

Providers shall review the service description for the particular service being provided and select the procedure code which most appropriately describes the service rendered and documented, and enter the appropriate procedure code for billing purposes in the record. Providers must meet the provider requirements as defined in Chapter II of this provider manual in order to secure service authorizations and registrations, provide the service and be reimbursed for the service.
The ARTS specific procedure codes and reimbursement structure is posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/ .

Records shall fully disclose the extent of services provided to Medicaid members. Records must clearly document that the services meet the requirements set forth in 12VAC30-130-5000 et al and in the Virginia *State Plan for Medical Assistance Services* and as set forth in this manual. If the required components are not present, reimbursement will be retracted. Providers shall maintain documentation that demonstrates that individuals providing services have the required qualifications established by DMAS, DHP or DBHDS.

The following section includes items that must be maintained in the individual's record.

The member's medical record shall include:

- Member and family strengths, needs, abilities and preferences that would facilitate recovery and opportunities to develop motivational strategies and treatment alliance;
- Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the member;
- Measureable treatment objectives with short-term and long-term goals;
- Any orders for medications, psychiatric, medical, dental, and any special healthcare needs, whether or not provided in the facility, education or special education, treatments, interventions, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member and the staff person responsible for providing those services;
- Plans for continuing care, including review and modification to the ISP;
- Detailed written discharge plan developed with the member; and
- Signature and date by the member or legally authorized representative, and the CATP(s) participating in the treatment team.
- The provider shall request releases of information from the member or legally authorized representative to release confidential information to collect information from medical and behavioral health treatment providers, schools, social services, court services, and other relevant parties. This information shall be used when considering changes and updating the ISP. The provider shall document steps to inform the member's primary care provider or pediatrician of the receipt of substance use disorder treatment services with appropriate releases meeting requirements of 42 CFR Part 2. Providers shall document evidence that for members receiving substance use case management and other ARTS levels of care, the collaboration between providers, given notification of the provision of services with appropriate consent meeting requirements of 42 CFR Part 2. In addition, the provider must send written monthly updates to the substance use case manager. A written discharge summary must be sent to the PCP and substance use case manager within 30 days of the service discontinuation date.

Multidimensional Assessment

A multidimensional assessment by a CATP, CSAC/CSAC-Supervisee, acting within the scope of their practice, and as defined in 12VAC30-130-5020, shall be required for ASAM levels of care 2.1 through 4.0. The CATP must sign off if completed by CSAC and CSAC-supervisee. The multidimensional assessment shall be maintained in the individual's record by the provider. Medical necessity for ASAM levels of care 1.0 to 4.0, Preferred OBAT and OTPs shall be based on the outcome of the individual's multidimensional assessment. The multidimensional assessment documentation shall support an individualized, person-centered biopsychosocial

assessment performed face-to-face (includes both in-person or via telemedicine), in which the provider obtains comprehensive information from the individual (including family members and significant others as needed) including the following:

- History of the present illness;
- Family history;
- Developmental history;
- Alcohol, tobacco, and other drug use or addictive behavior history;
- Personal/social history;
- Legal history;
- Psychiatric history;
- Medical history;
- Spiritual history;
- Review of systems;
- Mental status exam;
- Information available from current physical examination;
- Formulation and diagnoses;
- Survey of assets, vulnerabilities and supports; and
- Treatment recommendations.

The ASAM Multidimensional Assessment is a theoretical framework for this individualized, person-centered assessment that includes the following six dimensions: i) acute intoxication or withdrawal potential, or both, ii) biomedical conditions and complications, iii) emotional, behavioral, or cognitive conditions and complications, iv) readiness to change, v) relapse, continued use, or continued problem potential and vi) recovery/living environment. The level of care determination, ISP and recovery strategies development may be based upon this multidimensional assessment and the documentation shall support this framework being used. The multidimensional assessment shall be updated if there are changes in the member's medical or behavioral needs change or if the member transitions to a new ASAM Level of Care.

There is no required format for the Multidimensional Assessment; however all the required elements as listed above are required. The multidimensional assessment may be shared across level of cares if it is the same provider, but a new individual service plan (ISP) must be completed.

Interdisciplinary Plan of Care (IPOC)

The formatting of the IPOC may be at the discretion of the provider but must include all required components as stated.

The IPOC is a comprehensive treatment plan specific to the member's unique treatment needs. The IPOC is person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs, including care coordination needs and recovery goals, is regularly updated as the member's needs and progress change, and shows progress and or regression throughout the course of treatment. The documentation contains, but is not limited to:

- The member's treatment or training needs,
- The member's measurable goals,
- Measurable objectives and recovery strategies to meet the identified needs and goals,
- Services to be provided with the recommended frequency to accomplish the measurable goals and objectives,
- The estimated timetable for achieving the goals and objectives;
- An individualized discharge plan that describes transition to other appropriate services; and
- Be based on the ASAM Multidimensional Assessment.

Preferred OBATs and OTPs providers shall meet the specific documentation requirements for the Interdisciplinary Plan of Care (IPOC) as documented in the Supplement of this manual.

Interdisciplinary Plan of Care (IPOC) Provider Requirements

The IPOC must be developed and documented within 30 calendar days from the initial Individual Service Plan (ISP) by a CATP to address needs specific to the member's unique treatment.

The IPOC must be modified at a minimum of every 90 calendar days or as the needs and progress of the member changes. If Substance Use Care Coordination is being provided the IPOC must be reviewed monthly during the interdisciplinary treatment team meeting documented by a progress note.

A CATP must sign off on the IPOC/Comprehensive ISP if developed by a CSAC or CSAC-Supervisee.

The adult member must sign his or her own IPOC/Comprehensive ISP and if unwilling or unable to sign the IPOC/Comprehensive ISP, then the service provider must document the reasons why the member was not able or willing to sign the IPOC/Comprehensive ISP. The child's or adolescent's IPOC/Comprehensive ISP must be signed by the parent/legal guardian except in cases where a minor has been deemed an adult for purposes of consenting to medical or health

services needed for treatment of substance use disorder services meets requirements per §54.1-2969.

Individual Service Plans (ISP)

The formatting of the ISP may be at the discretion of the provider but must include all required components as stated.

All required initial and comprehensive ISPs must be completed as defined in 12VAC30-60-181 as well as document the following requirements in the member's medical record in accordance to Chapter IV of this manual and include the following:

- A summary or reference to the individual's identified needs.
- Short and long-term goals and measurable objectives for addressing each identified individually specific need.
- Services, supports and frequency of services to accomplish the goals and objectives including target dates for accomplishment and estimated duration of services.
- Role or roles of other agencies if plan is a shared responsibility and the staff designated as responsible for the coordination and integration of services.
- All ISPs shall be completed and contemporaneously signed and dated by the CATP preparing the ISP.
- If applicable, document if a family member or caregiver was involved in the development of the ISP or if assistance was provided if the individual's condition required such.
- The child's or adolescent's ISP shall be signed by the parent/legal guardian except in cases where a minor who is deemed an adult for purposes of consenting to medical or health services needed for treatment of substance use disorder services meets requirements per §54.1-2969.
- For children and adolescents, the signature of the parent/legal guardian must be included or documented reasons why he/she was unable or unwilling to sign the ISP.
- Include the signature of the individual receiving services (adults) or the reason why the individual was unable or unwilling to sign the ISP.
- There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate a document verifying freedom of choice of providers was offered and this provider was chosen.
- ISP (s) should be reviewed on a consistent basis to ensure treatment goals are being meet and are still applicable to the individual treatment needs of the member.

To effectively implement the ASAM Criteria in programs that offer multiple levels of care, the ISP should clearly document the level(s) of care that a member is in at a given time. If the member is concurrently receiving treatment at another level of care (e.g., withdrawal management or opioid treatment services), it should be clearly documented in the medical record. The program should have policies and procedures in place that clearly differentiate the standards of care that should be delivered to members within each level. Specific policies and procedures should indicate which level(s) they apply to, and processes should be in place to ensure that the minimum standards for a given level of care are followed for all members served at that level.

ISP (s) that do not include all required elements specified in in 12VAC30-60-181 and 12VAC30-60-185 as well as the requirements in Chapter IV shall be considered incomplete and not meeting the reimbursement requirements.

Individual Service Plan (ISP) Provider Requirements

Each of the ASAM level of cares have specific requirements for signature and co-signature requirements for the ISP:

- ASAM 2.1, 2.5, 3.1-3.7: CATP, CSAC/CSAC-Supervisee in collaboration with interdisciplinary team. The CATP must sign off if completed by CSAC and CSAC-supervisee.

- ASAM 4.0: An interdisciplinary staff of appropriately credentialed clinical staff including CATPs and registered nurses.

Progress Notes

Daily service documentation shall support the medical necessity criteria and how the individual's needs for the service continue to match the level of care criteria. **This documentation shall be written, signed, and dated at the time the services are rendered or within one business day from the time the services were rendered.** Progress notes, as defined in 12 VAC 30-130-5020, shall disclose the extent of services provided and corroborate the units billed. Claims not supported by corroborating progress notes may be subject to recovery of expenditures.

Progress notes must be documented and comprehensive as defined in 12VAC30-130-5020 for each service that is billed and shall include the following, at a minimum:

- Name of the service rendered;
- Date of the service rendered;
- Signed and contemporaneously dated by the person who rendered the service and prepared the notes including credentials of the person;
- Amount of time or units/hours required to deliver the service;

- Convey the individual's circumstances, treatment and progress, or lack of progress, toward goals and objectives in the ISP;
- Specific staff interventions;
- Setting in which the service was rendered;
- Content of each progress note shall corroborate the time/units billed;

DMAS shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services if the supporting documentation does not demonstrate unique differences particular to the individual.

Daily Progress Notes Provider Requirements

Daily progress notes for therapy sessions conducted by a Residents and Supervisees under supervision there must be a co-signature of the Licensed CATP.

There is no co-signature requirement for daily progress notes to include group notes, activities or call logs, substance use case management and or care coordination notes for psychoeducational services. Co-signature of these daily activities is not required within any ASAM level of care being provided by CSAC or CSAC-A, or bachelor's level staff for substance use care coordination. The supervising practitioner or Licensed CATP should review documentation prior to placement within the member records.

Service Authorization Requirements

Providers are required to reassess a member after they have been discharge from treatment greater than 10 days. The same provider can share and collaborate across service for a members care but should be sure to review and ensure that the member's needs are updated within the assessment.

All amended and updates to documentation must be reviewed, signed and dated.

Substance Use Case Management Documentation Requirements

The following utilization review criteria apply to substance use case management as defined in 12VAC30-60-185.

- Assessing needs and planning services to include developing a substance use case management ISP developed with the individual, in consultation with the individual's family, as appropriate as defined in 12VAC30-130-5020.
- An ISP shall be completed within 30 calendar days of initiation of this service with the individual in a person-centered manner and shall document the need for active substance use case management before such case management services can be billed. The ISP shall require a minimum of two separate and distinct case management activities to be performed each calendar month and a minimum of one face-to-face client contact at least every 90 calendar days that does not count towards the monthly minimum of two separate and distinct case management activities.
- The substance use case manager shall review the ISP with the individual at least every 90 calendar days for the purpose of evaluating and updating the individual's progress toward meeting the ISP objectives. The review will be due by the 90th calendar day following the date the last review was completed. The reviews shall be documented in the individual's medical record. DMAS will allow a grace period to be granted up to the 120th calendar day following the date of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled 90 calendar days from the date the review was initially due and not the date of actual review.
- The ISP shall be reviewed with the individual present, and the outcome of the review documented in the individual's medical record.
- The ISP shall be updated and documented in the individual's medical record at least annually and as an individual's needs change.
- All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative and any relevant family members or friends involved in the development of the ISP must sign the ISP, including reviews and updates to the ISP.
- There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate a document verifying freedom of choice of providers was offered and this provider was chosen.
- A release form must be completed and include the dated signature of the individual for the release of any information.
- There must be an ISP from each provider rendering services to the individual. The ISPs must state long-term service goals and specified short-term objectives in measurable terms.
- Case Management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual

declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Substance Use Case Management Progress Notes

Progress notes must be documented and comprehensive as defined in 12VAC30-130-5020 for each service that is billed and shall include the following, at a minimum:

- Name of the service rendered;
- Date of the service rendered;
- Signed and contemporaneously dated by the person who rendered the service and prepared the notes including credentials of the person;
- Amount of time or units/hours required to deliver the service;
- Convey the individual's circumstances, treatment and progress, or lack of progress, toward goals and objectives in the ISP;
- Specific staff interventions;
- Setting in which the service was rendered;
- Content of each progress note shall corroborate the time/units billed;
- All attempts to conduct home visits both successful and unsuccessful must be appropriately documented within the member's patient record.

DMAS shall not reimburse for dates of services in which the progress notes are not individualized and case-specific. Duplicated progress notes shall not constitute the required case-specific individualized progress notes. Each progress note shall demonstrate unique differences particular to the individual's circumstances, treatment, and progress. Claim payments shall be retracted for services that are supported by documentation that does not demonstrate unique differences particular to the individual.